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	157285	A. BUILDING _____ B. WING _____	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANTAGE HOME HEALTH CARE INC	4008 N WHEELING AVE MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This visit was a home health agency federal recertification survey. This was an extended survey. Survey dates: November 14, 15, 16, and 17, 2011 Partially extended November 15, 2011 10:15 AM Fully extended November 17, 2011 9:15 AM Facility #: 007116 Medicaid Vendor : 100374770 Surveyors: Susan E. Sparks, RN, PH Nurse Surveyor Bridgett Boston RN, PH Nurse Surveyor Census: Skilled patients 398 Home health aide only 629 Personal service only 45 Total 1, 072 Quality Review: Joyce Elder, MSN, BSN, RN November 28, 2011 This survey was modified as the result of an IDR 1/17/11. je	G 000		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.	G 121		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This STANDARD is not met as evidenced by:
Based on observation, interview, and policy review, the agency failed to ensure the staff followed infection control and safe practices in 2 of 6 home visits conducted. (1 and 2)

Findings:

1. On 11/15/11 at 7:50 AM, Employee K was observed with patient/clinical record # 8. The patient is a quadriplegic. The patient needed the gauze around the suprapubic catheter tube changed. The home health aide used the scissors laying on the table and did not clean them to cut the 2 x 2 gauze. She prepared one basin of water, though there were two basins available for use. She used one white and one brown washcloth for care. The aide washed the upper body/feet and legs. She changed the water. She did not have a clean washcloth. She washed the suprapubic area. She removed the bloody gauze from around the tubing and states, "I've not seen one of these before." She washed the penis, which was red and excruciated, and then scrubbed the area around the catheter tube till it was bleeding. The supervising nurse, Employee L, washed her hands and gloved. She used the same washcloth from the water to rinse around the tube and replace the gauze. The aide continued the bath switching the soap and rinsing washcloth as she reached into the water. The patient was out of alcohol wipes. The aide prepared to go from the catheter bag to a leg bag, so she used the non-alcoholic baby wipes to clean the connectors. The patient was rolled several times during the bath and dressing

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without safety rails being raised on the alternate side. The patient wanted to be placed in the motorized chair for the day. The aide got the Hoyer from the closet. She placed the closed legs under the bed. She fit the sling under the patient and attached the sling to the crossbars. She used the hydraulic to the lift the patient. She then moved the patient to the chair, using the Hoyer, rather then moving the chair to the Hoyer. At no time did she spread the legs of the Hoyer.

On 11/15/11 at 10:15 AM, Employees B and Employee C indicated the legs of the Hoyer should always be spread for stability and the chair should be brought to the patient. The Hoyer is not to be used for transportation.

2. On 11/15/11 at 9:30 AM, Employee J, licensed practical nurse (LPN), was observed performing wound care on patient/clinical record # 6. The patient had two non healing wounds on each side the abdomen. The LPN gloved without sanitizing her hands. The LPN placed her supplies directly on the patient's bed, removed the bandages from the left side of the abdomen, and pulls the gauze from the wound. Without changing her gloves, she opened the gauze, saturates it with normal saline and repacked the wound. She covered it with a 4x6 dressing. She couldn't get the tape to work with her gloves on so she took them off and stated, "Right or wrong, this is how I do it." and taped the bandage on. She then put on new gloves without sanitizing her hands and repeated the same process for the right side of the abdomen.

3. An undated policy titled "Infection Control, Universal Precautions, and Waste Management"

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G 121	Continued From page 3 states, "1. Wear disposable gloves for any contact with blood, body secretions, open wounds, or mucous membranes. Gloves are also necessary for handling items or surfaces contaminated with blood or body fluids. ... 2. Wash your hands before patient contact and immediately after gloves are removed."	G 121		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse completed a reevaluation of the patient that was comprehensive and addressed the patient's needs and was completed in the 56 - 60 day window for 5 of 10 (# 1, 2, 4, 5, and 10) clinical records reviewed of patients receiving services for at least 60 days with the potential to affect all the agency's 1027 patients requiring assessments. Findings include: 1. Clinical record # 1, start of care (SOC) 1/17/11, included a "Recertification Reassessment" completed 3/17/11 by Employee G, a registered nurse. The assessment failed to evidence the nurse conducted a Braden assessment as would be appropriate for patient #1 as the patient had documented pressure ulcers. 2. Clinical record # 2, SOC 4/17/11, included a	G 172		

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"Recertification Reassessment" completed 10/13/11 by Employee H, a registered nurse. The assessment failed to evidence the nurse completed a fall risk assessment as would be appropriate for patient #2 as the patient had left sided weakness, blindness, and functional limitations with ambulation.

3. Clinical record # 4, SOC 10/31/07, included a "Recertification Reassessment" completed 10/10/11 (day 61) by Employee H, a registered nurse, for the certification period 10/10/11 - 12/8/11.

On 1/16/11 at 9:45 AM, Employee C, Director of Nursing, indicated the assessment was completed day 61.

4. Clinical record # 5, SOC 1/10/11, included a "Recertification Reassessment" completed 3/11/11 (day 61) by Employee G, a registered nurse, for the certification period 3/11/11 to 5/9/11.

On 1/16/11 at 9:45 AM, Employee C, Director of Nursing, indicated the assessment was completed day 61.

5. Clinical record # 10, SOC 8/22/03, evidenced a plan of care for the certification period 10/31/11 through 12/29/11 with orders for skilled nursing 5 days a week throughout the certification period. The record failed to evidence a comprehensive assessment was completed for the plan of care dated 10/31/11.

6. The policy titled "OASIS / COMPREHENSIVE ASSESSMENT DATA COLLECTION AND

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G 172	Continued From page 5 SUBMISSION POLICY" states, "3) All other home care patients will receive: ... b) a comprehensive reassessment (OASIS Recertification) to be performed within the last 5 days of every 60 days beginning with the SOC [start of care] date, ... 4) ... Recertification, resumption and other follow up assessments require onsite visits." 7. The policy titled "Nursing Supervision Policy" states, "The nursing supervisor will: ... regularly evaluate the patient's nursing needs. Initiate the plan of care and make necessary revisions. ... The nursing supervisor will establish a plan of care (MD orders) with the patient's physician. This plan of care will be reviewed by the supervisor and physician every 60 days. ... The nursing supervisor will also be responsible for ongoing evaluation of the plan of care."	G 172		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse completed the new recertification plan of care based on a comprehensive assessment and initiated the plan of care the day of the assessment if the assessment wasn't completed in the 5 day window for 6 of 7 clinical records reviewed of patients that received services for greater than 60 days with the potential to affect all the agency's 1027 patients requiring assessments. (# 1, 2, 3, 4, 9, and 10)	G 173		

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Findings include:

1. Clinical record # 1, start of care (SOC) 1/17/11, included a "Recertification Reassessment" completed 3/17/11 by Employee G, a registered nurse. A "60 Day Summary" dated 3/17/11 indicates the Plan of Care was submitted to the doctor for signature on 3/4/11 and signed on 3/9/11, prior to the reassessment date.

2. Clinical record # 2, SOC 4/17/11, included a "Recertification Reassessment" completed 10/13/11 by Employee H, a registered nurse. A "60 Day Summary" dated 10/13/11 indicates the Plan of Care was submitted to the doctor for signature on 9/29/11 and signed on 10/5/11, prior to the reassessment date.

3. Clinical record # 3, SOC 7/7/11, included a "Recertification Reassessment" completed 11/2/11 by Employee I, a registered nurse. A "60 Day Summary" dated 11/4/11 indicated the Plan of Care was submitted to the doctor for signature on 10/20/11 and signed on 10/25/11, prior to the reassessment date.

On 1/16/11 at 9:45 AM, Employee C, Director of Nursing, indicated there are timing issues because of the guidelines between assessments and plans of cares and physician orders.

4. Clinical record # 4 SOC 10/31/07, included a "Recertification Reassessment" completed 10/10/11 (day 61) by Employee H, a registered nurse. A "60 Day Summary" dated 10/7/11 indicated the Plan of Care was submitted to the

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G 173	Continued From page 7 doctor for signature on 9/26/11 and signed on 10/7/11, prior to the reassessment date. 5. Clinical record # 9, SOC 7/5/11, included a "Recertification Reassessment" dated 8/24/11 (day 61) by Employee E, a registered nurse, for the certification period 9/3/11 - 11/1/11. A "60 Day Summary" dated 9/2/11 indicated the Plan of Care was submitted to the doctor for signature on 8/17/11 and signed on 8/24/11, prior to the reassessment date. The assessment was not completed in the 5 day window which would have required the next certification period to begin 8/24/11. The record contained a second "Recertification Reassessment" dated 10/19/11 (day 61) by Employee D, a registered nurse, for the certification period 11/2/11 - 12/31/11. A "60 Day Summary" dated 11/1/11 indicated the Plan of Care was submitted to the doctor for signature on 10/17/11 and signed on 10/21/11, prior to the reassessment date. The assessment was not completed in the 5 day window which would have required the next certification period to begin 10/19/11. 6. Clinical record # 10 SOC, 8/22/03, included "Recertification Reassessment" dated 8/23/11 by employee F for the certification period 9/1/11 -10/30/11. The record evidenced a plan of care for the certification period 9/1/11 through 10/30/11 that contained the signature of the physician dated 8/19/11, 4 days prior to the reassessment date. The assessment was not completed in the 5 day window which would have required the next certification period to begin 8/23/11.	G 173		

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G 173	Continued From page 8 B. The clinical record evidenced a plan of care for the certification period 10/31/11 through 12/29/11. The plan of care beginning 10/31/11 was signed by the physician on 10/13/11 and noted by employee D as received on 10/18/11, 13 days prior to the date of the document titled "Recertification Assessment." C. On November 15, 2011, at 5:38 PM, employee D indicated she wrote the plans of care based on the most recent supervisory note that was available to her in the office on the date she wrote the plan of care and not on the comprehensive assessment. 7. On November 15, 2011, at 4:30 PM, employee D indicated she is creating the plan of care and sending to the physician before completing the reassessment.	G 173		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure supervisory visits were made every 14 days in 2 of 3 of clinical records with skilled services and home health aide services. (# 1 and 2) Findings: 1. Clinical record 1, start of care (SOC) 1/17/11,	G 229		

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G 229	Continued From page 9 evidenced a plan of care (POC) for 3/18/11 to 5/16/11 with orders for skilled nursing and home health aide services. The clinical record failed to evidence a supervisory visit was made to evaluate the home health aide by the registered nurse. 2. Clinical record 2, SOC 4/17/11, evidences a POC for 10/14/11 to 12/12/11 with orders for skilled nursing and home health aide services. The record fails to evidence a supervisory visit was made to evaluate the home health aide by the registered nurse. 3. On 11/15/11 at 1 PM, the Administrator, Employee A, indicated she was unaware of any requirement to supervise the aides with skilled services every 14 days and they had not been doing so.	G 229		
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse completed a reevaluation of the	G 339		

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patient that was comprehensive and addressed the patient's needs and was completed in the 56 - 60 day window for 6 of 10 (# 1, 2, 4, 5, and 10) clinical records reviewed of patients receiving services for at least 60 days with the potential to affect all the agency's 1027 patients requiring assessments.

Findings include:

1. Clinical record # 1, start of care (SOC) 1/17/11, included a "Recertification Reassessment" completed 3/17/11 by Employee G, a registered nurse. The assessment failed to evidence the nurse conducted a Braden assessment as would be appropriate for patient #1 as the patient had documented pressure ulcers.

2. Clinical record # 2, SOC 4/17/11, included a "Recertification Reassessment" completed 10/13/11 by Employee H, a registered nurse. The assessment failed to evidence the nurse completed a fall risk assessment as would be appropriate for patient #2 as the patient had left sided weakness, blindness, and functional limitations with ambulation.

3. Clinical record # 4, SOC 10/31/07, included a "Recertification Reassessment" completed 10/10/11 (day 61) by Employee H, a registered nurse, for the certification period 10/10/11 - 12/8/11.

On 1/16/11 at 9:45 AM, Employee C, Director of Nursing, indicated the assessment was completed day 61.

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4. Clinical record # 5, SOC 1/10/11, included a "Recertification Reassessment" completed 3/11/11 (day 61) by Employee G, a registered nurse, for the certification period 3/11/11 to 5/9/11.

On 1/16/11 at 9:45 AM, Employee C, Director of Nursing, indicated the assessment was completed day 61.

5. Clinical record # 10, SOC 8/22/03, evidenced a plan of care for the certification period 10/31/11 through 12/29/11 with orders for skilled nursing 5 days an week throughout the certification period. The record failed to evidence a comprehensive assessment was completed for the plan of care dated 10/31/11.

6. The policy titled "OASIS / COMPREHENSIVE ASSESSMENT DATA COLLECTION AND SUBMISSION POLICY" states, "3) All other home care patients will receive: ... b) a comprehensive reassessment (OASIS Recertification) to be performed within the last 5 days of every 60 days beginning with the SOC [start of care] date, ... 4) ... Recertification, resumption and other follow up assessments require onsite visits."